Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2969HOS	A. BUILDING _____ B. WING _____	06/01/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ROSE DOMINICAN HOSPITAL - SIENA C	3001 ST ROSE PARKWAY HENDERSON, NV 89052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 6/1/10, in accordance with Nevada Administrative Code, Chapter 449, Hospitals. Complaint #NV00025281 was substantiated with deficiencies cited. (See Tag S0300) Complaint #NV00025227 was substantiated with deficiencies cited. (See Tag S0143,324,300) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were also identified during the complaint investigation.	S 000	S 143 NAC 449.332 b.) All behavioral health patients held for Legal 2000 purposes and discharged from the ED have the potential to be affected by the identified deficient practice. c.) The ED charge nurse on duty prior to discharge/transfer will review the medical record of all Legal 2000 patients. The review will include documentation of physician order to discharge or transfer. This new process was communicated to all charge nurses on throughout month of June via one-to-one personal/verbal communication by the ED Manager. d.) ED Manager or designee will perform monthly monitoring of 20 Legal 2000 patients for written order to discharge or transfer. Data will be tracked, trended, evaluated, and communicated to ED staff and hospital leadership. Action plans will be developed and communicated to hospital leadership when appropriate. This measurement period will begin July 1, 2010 last through the end of 2010 with potential for extension as needed and deemed by Emergency Services and hospital leadership. e.) Responsible Party: Manager, Emergency Services. S 300 NAC 449.3622 b.) All patients presenting to Emergency Department admitting/triage with cardiac symptoms are identified as having potential to be affected by the identified deficient practice. c.) We are confident that our stated deficiencies lay in documentation of monitoring and treatment, rather than the timing of the treatment & monitoring itself.	6/30/10 6/30/10
S 143 SS=D	NAC 449.332 Discharge Planning 1. A hospital shall: (a) Have a process for discharge planning that applies to all inpatients; and (b) Develop and carry out policies and procedures regarding the process for discharge planning.	S 143		

6-23-10 Accepted Dgm

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Teresa Conley — TITLE COO — (X6) DATE 6/22/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 143	Continued From page 1 This Regulation is not met as evidenced by: Based on interview and record review, Patient #2 was discharged from the facility without a written physician's order. Severity: 2 Scope: 1	S 143	Because of this, educational emphasis has been placed on documentation. Education has and will be implemented via staff meetings (scheduled for beginning of July), shift huddles (Exhibit A: ED Huddle book – June 2010 and staff assignments of who participated in the huddles), and newsletters (next newsletter scheduled to be published first week in July). ED clinical educator, Manager of Emergency Services, and shift charge nurses to provide education. Education to be completed by June 24th, 2010. This same education will also be conveyed in future department orientation to all staff. d. Monthly closed record review will be performed on 30 cardiac-related patients by the Manager of Emergency Services or designee. Performance measurements include: • Arrival time to triage time • Time from triage to cardiac monitoring (including documentation of rhythm) • Time from triage to treatment (including oxygen application, IV insertion and other cardiac treatment modalities) • Time from triage to seen by ED physician Quality Management Systems staff will continue to measure and report door to ECG times to ED staff and hospital leadership (Exhibit B: Mean Time to EKG Graph – October 2008-April 2010). Action plans will be developed and communicated to hospital leadership when appropriate. This measurement period will being July 1, 2010 and last a minimum of 3 months with potential for extension as needed and deemed by hospital leadership (Mean time EKG is	
S 300 SS=E	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on interview, record review and document review, the facility failed to provide cardiac monitoring for Patient #1 upon arrival to the facility. Patient #1 had a history of multiple myocardial infarctions. Based on interview, record review and document review, the facility failed to provide suicide precautions to Patient #3 per the facility policy. Severity: 2 Scope: 2	S 300		
S 324 SS=E	NAC 449.3628 Physical Restraint Use 4. The governing body shall develop and carry out organizational policies and procedures that limit the use of physical restraints on patients to only those situations in which the use of physical restraints is appropriate and for which there is	S 324		

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S 324	Continued From page 2 adequate clinical justification. This Regulation is not met as evidenced by: Based on interviews, record reviews and documentation review, the facility failed to follow the physical restraint policy. 1. Patient #2, #3 and #4 were placed in physical restraints. None of the patients received a debriefing after release of the restraints. 2. A physician's order to continue physical restraints was not obtained until after Patient #4 had been in the restraints for five hours. 3. Patient #4 remained in physical restraints when the observation record revealed the patient was lying quietly in the patient's room. Severity: 2 Scope: 2	S 324	ongoing per ACS requirements). e. Responsible Party: Manager of Emergency Services. S324 NAC449.3628 b.) All patients requiring physical restraint for violent/self-destructive indications are identified as having potential to be affected by the identified deficient practice. c.) Form to address violent/self-destructive physical restraint has been developed (Exhibit C: SRDH Trial Debriefing Form and CIS electronic documentation screen shots). This form will be implemented for trial/pilot period, and be submitted for permanent approval after suggested revisions made (if needed). ED staff restraint education (Exhibit D: Restraint Education & Post Test) and debriefing strategies have and will be performed by clinical educator and ED manager throughout June and July. d.) ED Manager or designee will perform monthly monitoring of 100% of Violent/ Self-destructive physical restrained patients via closed record review (Exhibit E: Restraint Data Tool). Data will be tracked, trended, evaluated, and communicated to ED staff and hospital leadership. Action plans will be developed and communicated to hospital leadership when appropriate. This measurement period will begin July 1, 2010 last through the end of 2010 with potential for extension as needed and deemed by Emergency Services and hospital leadership. e.) Responsible Party: Manager, Emergency Services.	6/30/10